An Idaho Employer's Guide to Health Care Reform

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What We Will Cover

- Health Care Reform Background
- Implementing Health Care Reform in Idaho
- Top Health Care Reform Issues for Employers through 2014

Health Care Reform

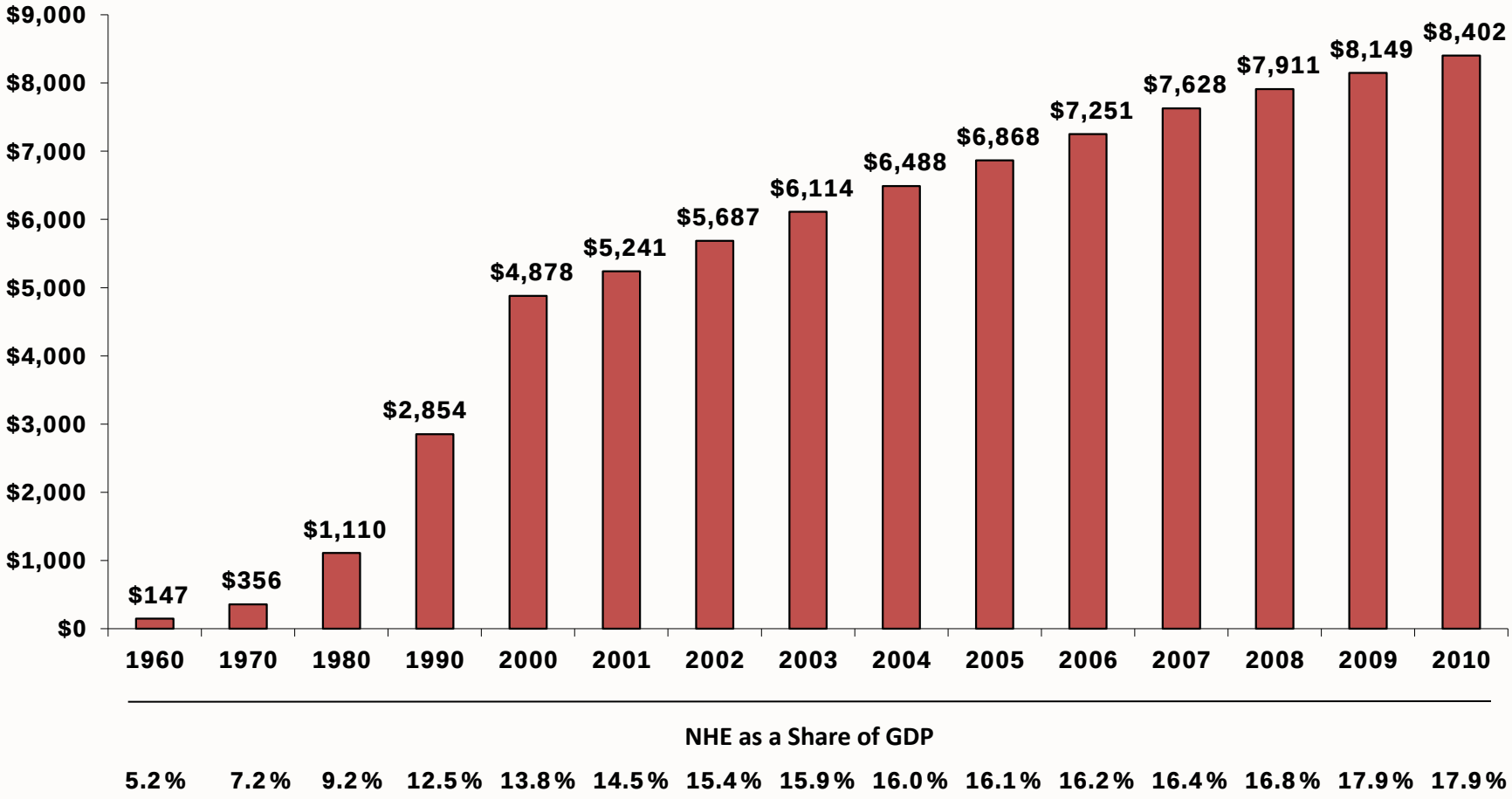
What got us into this mess?

Why is reform needed?

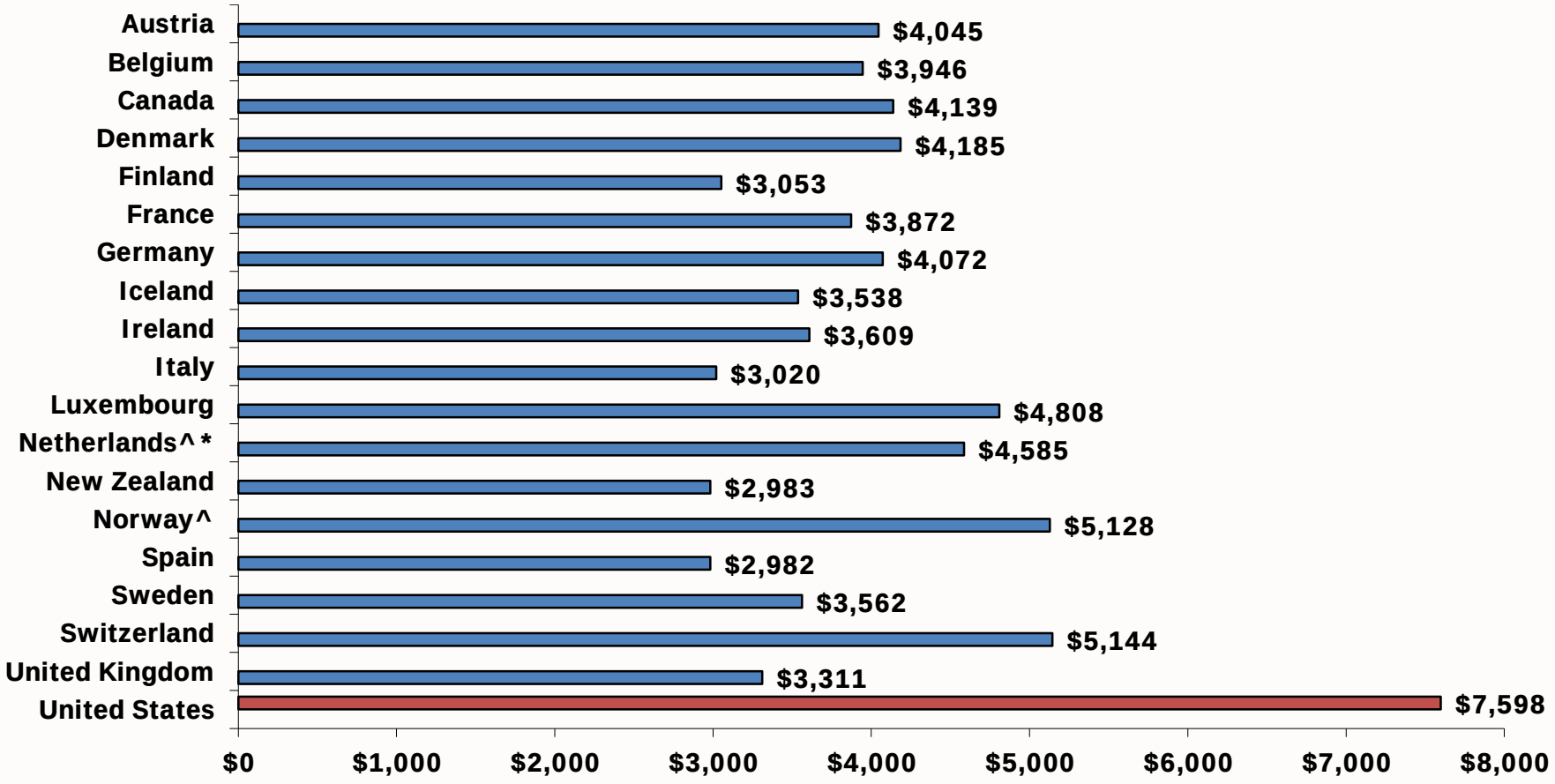
Health Care Reform

- Background facts
- Courtesy of the Henry J. Kaiser Family Foundation – and the Internet
- Some editorial license taken (minor)
- www.kff.org

National Health Expenditures per Capita, 1960-2010



Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2009



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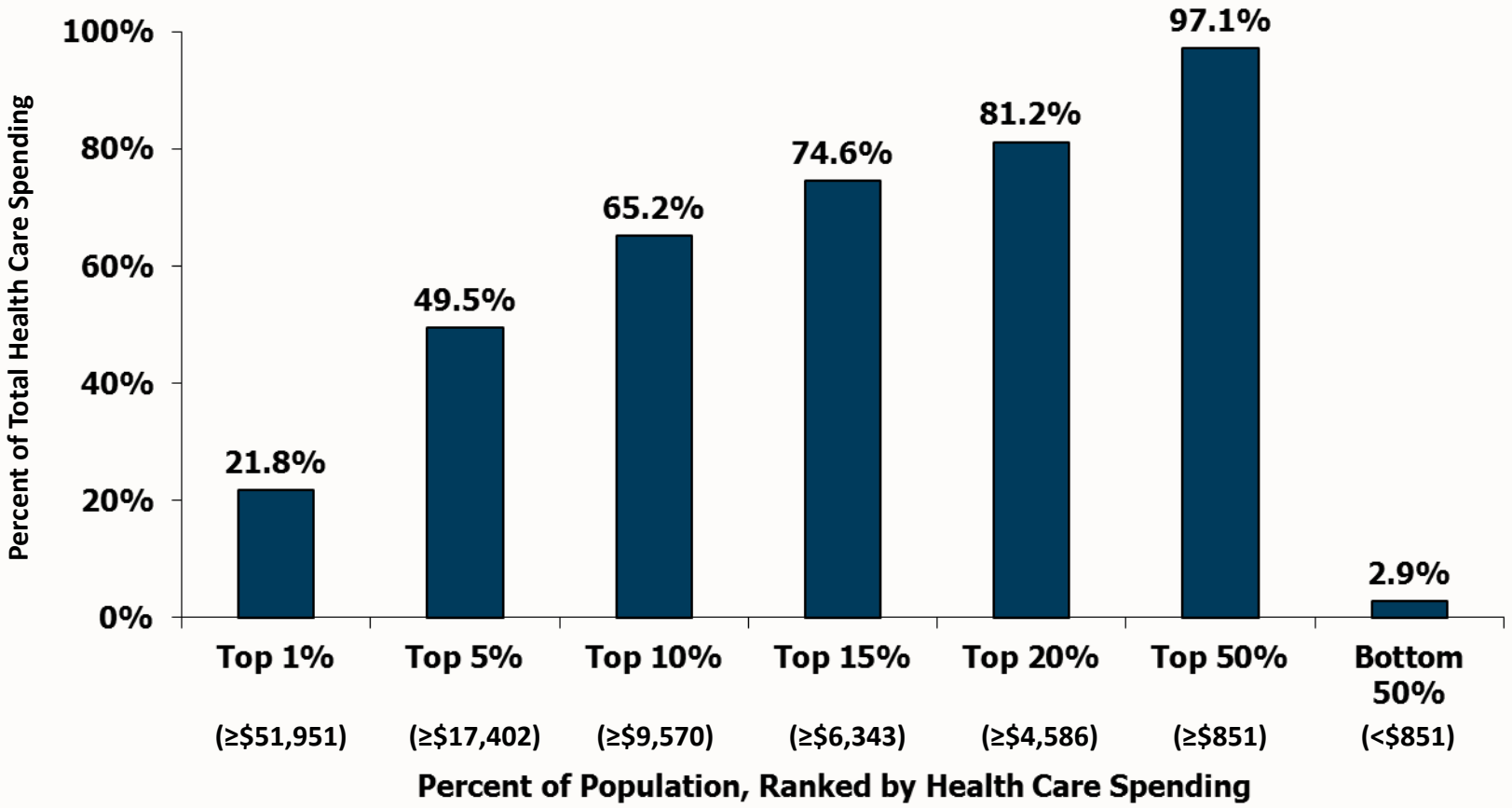
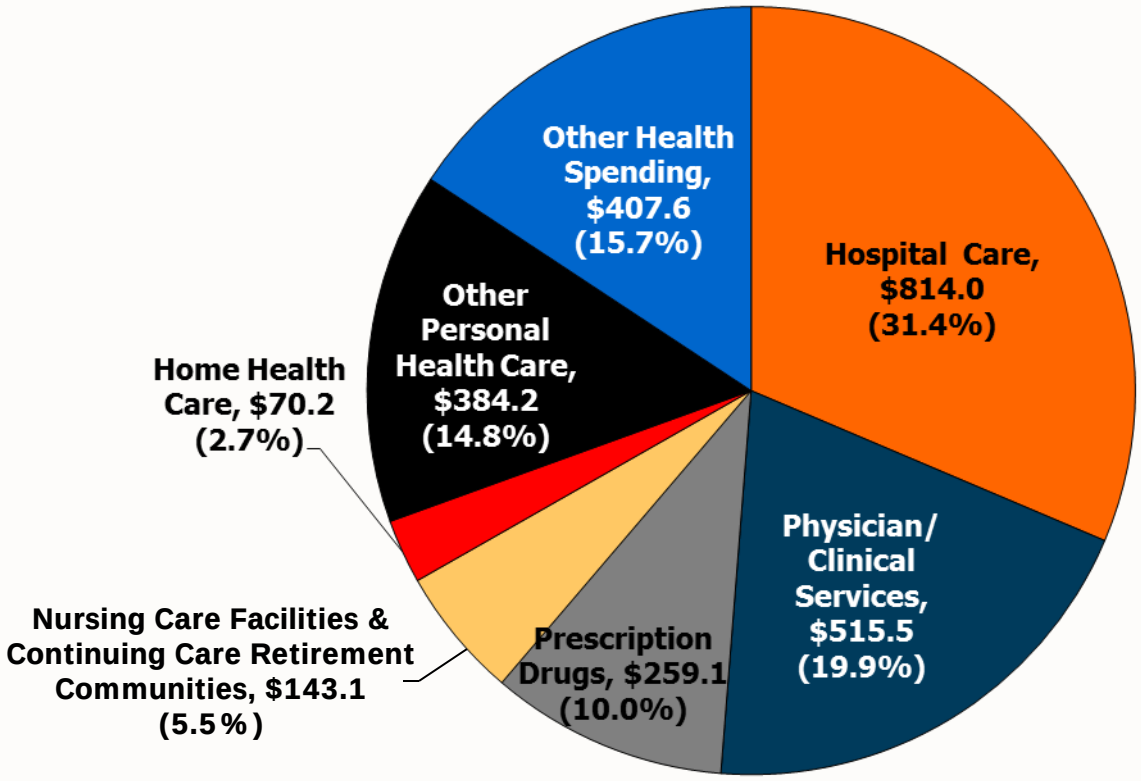
Concentration of Health Care Spending in the U.S. Population, 2009



Distribution of Average Spending Per Person, 2009

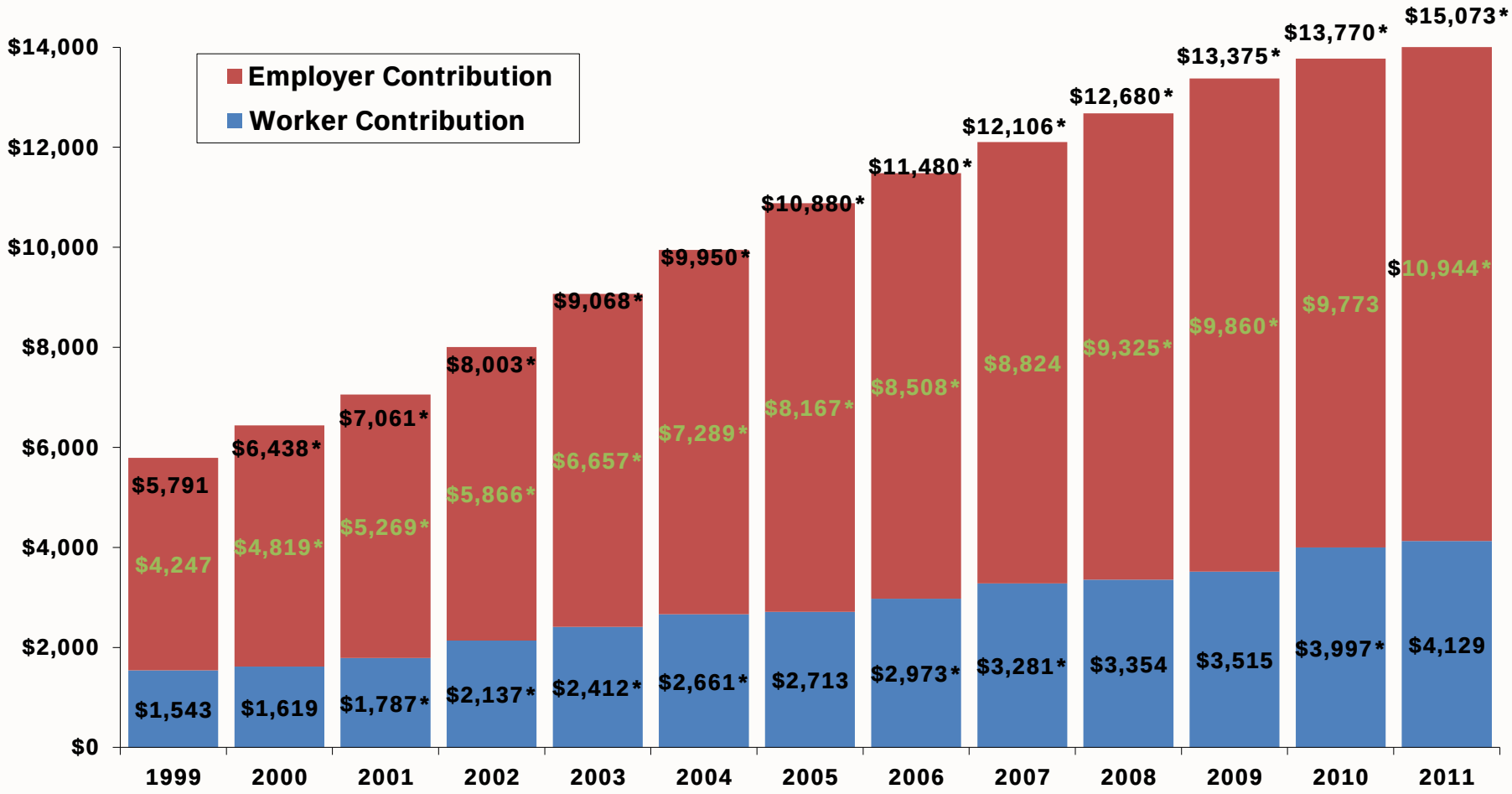
	Average Spending Per Person
Age (in years)	
<5	$2,468
5-17	1,695
18-24	1,834
25-44	2,739
45-64	5,511
65 or Older	9,744
Sex	
Male	$3,559
Female	4,635

Distribution of National Health Expenditures, by Type of Service (in Billions), 2010



NHE Total Expenditures: $2,593.6 billion

Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2011



Health Care Reform

- The Affordable Care Act (ACA) – a very high-level overview:
  - Expands health care coverage to 30 million additional Americans, aka the "individual mandate," but leaves 26 million uninsured
  - Establishes health insurance exchanges
  - Authorizes the payment of federal subsidies to pay for health care coverage
  - Penalizes employers for not providing coverage
  - Expands Medicaid income eligibility to 133% of federal poverty level (if elected by states)

Health Care Reform

The ACA and Idaho:

- If Medicaid eligibility expanded, additional 80,000 people will be eligible for Medicaid
- Federal portion of cost for expanded eligibility will be 100% in 2014, dropping to 90% in 2020
- Families of four with incomes less than $30,656 will be eligible

Health Care Reform

A key component of expanding coverage is the establishment of health insurance exchanges.

- An exchange is a web-based portal that is a one-stop shop for purchasing health insurance
- Individuals and employers with 100 employees or less are eligible to purchase on the exchange
- Undocumented immigrants not eligible
- Exchange will determine Medicaid eligibility and direct eligible participants to Medicaid

Health Care Reform

Health insurance exchanges (con't.):

- For those not eligible for Medicaid, federal subsidies are available to purchase private insurance, but only if purchased on the exchange
- On a sliding-scale basis, federal subsidies are available for families with incomes up to 400% of poverty level ($92,200 for a family of four) e.g. most of Idaho

Health Care Reform

Health insurance exchanges (con't.):

- State-controlled or federally-controlled?
- If states don't implement an exchange, the state's exchange will be a federal exchange set up, governed, and operated by the federal government
- If a federal exchange, no guarantee that domestic insurers will be permitted to sell insurance on the exchange

Implementing Health Care Reform in ID

What needs to happen now in Idaho?

- Decision on establishing a state-based exchange
- Decision on expanding Medicaid
- The Idaho Senate approved a bill establishing a state-based exchange. The bill now moves to the Idaho House.
- Governor Otter's Medicaid expansion work group is still developing policy.

Top Health Care Reform Issues for Employers through 2014

- Small business tax credit
- FICA tax increase
- PCORI fee
- Notice of insurance exchanges
- 90-day waiting period
- Shared responsibility
- Wellness programs
- Transitional Reinsurance Program fee
- On the horizon

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Small Business Tax Credit

- Small employers with fewer than 25 FTEs with average annual wages of $50,000 (or less) may be eligible for a tax credit for providing qualifying employer health coverage.
- Generally credit may be claimed to offset taxable income of a for profit employer or the Medicare tax obligation of a tax exempt employer.
- Credit equal to 35% (50% after 2013) of qualifying premiums paid by a for-profit employer and 25% (35% after 2013) of qualifying premiums paid by a tax exempt employer.
- Credit reduced on sliding scale if the employer has more than 10 FTEs or FTEs make on average more than $25,000
- Employee owners (and their compensation) are not taken into account for purposes of determine FTE count or average wages.
- Does not apply to self-insured arrangements.

FICA Tax Increase

- Effective January 1, 2013, Medicare tax rate increase of 0.9% for wages over $200,000 ($250,000 for married couples filing jointly)
  - Employers must withhold an additional 0.9% from employee wages over $200,000
  - No impact on employer's share of the Medicare tax
- Also note new tax on investment income – 3.8% tax on the lesser of
  - Net investment income (interest, dividends, etc.)
  - Modified AGI in excess of $200,000 ($250,000 for married couples filing jointly)

PCORI Fee

- Patient-Centered Outcomes Research Institute (PCORI) Fee
- Fee based on average number of covered lives (including participants, spouses and dependents)
  - $1 per life for 2012
  - $2 per life for 2013
  - Adjusted for medical inflation in subsequent years
  - 2018 is last year for calendar year plans
- Payment due to the IRS by the following July 31 (Form 720)
- Methods for calculating average number of covered lives
  - Actual Count Method – count covered lives on each day in the year
  - Snapshot Count Method – count covered lives on at least one day per quarter
  - Snapshot Factor Method – count participants on at least one day per quarter and multiply participants with spouse/family coverage by 2.35
  - Form 5500 Method – add participant count from Form 5500 for the year on first day to participant count on last day (for self-only plans, divide by 2)
- Retirees and COBRA beneficiaries are counted, except retirees covered under stand-alone, fully insured arrangement

PCORI Fee

- Insurers calculate and pay for insured plans
- Sponsors calculate and pay for self-insured plans, including FSAs and HRAs, but not HSAs
- Not required to double count multiple self-insured arrangements if the arrangements have same plan year
  - For example, self-insured major medical with an HRA
- Insurer and sponsor both pay fee if insured and self-insured arrangements cover the same employee
  - For example, insured major medical with an HRA
- Not a plan expense

Notice of Insurance Exchanges

- Employers are required to provide a notice to all employees explaining:
  - Exchanges
  - Possible subsidies available on exchanges
- Regulators issued guidance that additional guidance would be issued
  - Will likely be required to be provided during open enrollment for 2014
  - Model notice will likely be provided

90-Day Waiting Period

- Effective January 1, 2014, waiting periods are limited to 90 days after the employee otherwise meets eligibility requirements
  - Plan eligibility may be conditioned on other factors, such as
    - Employment classification (hourly and part-time employees may be excluded)
    - 1,200 hours of service (but not more than 1,200 hours of service)
  - No shared responsibility penalties apply during a waiting period

Shared Responsibility Requirements

- Sponsors need to review requirements now so that they have time to modify plans, if needed
- Individual mandate forces most employees to obtain coverage or pay a tax
- Employer mandate requires employers to provide coverage to employees or pay a Shared Responsibility Penalty
- Key Concepts:
  - Large Employer – Shared Responsibility Penalty only applies to employers with 50 or more full-time (or full-time equivalent) employees
  - Minimum Essential Coverage – coverage that provides standard medical benefits
  - Minimum Value Coverage – Minimum Essential Coverage that pays at least 60% of medical costs (determined actuarially)
  - Affordable Coverage – the employee's premium for Minimum Value Coverage is 9.5% of the employee's household income or less

Big Picture

- Shared Responsibility Penalties. If you are a Large Employer **and** you do not provide a plan with Minimum Essential Coverage to at least 95% of your full-time employees **or** you offer a plan that provides Minimum Essential Coverage, but the plan does not provide Minimum Value Coverage that is Affordable Coverage, you **may** have to pay a Shared Responsibility Penalty.
- Premium Assistance. Shared Responsibility Penalties do not apply unless one or more employee receives premium assistance on an exchange. Premium Assistance is available if Minimum Value Coverage that is Affordable Coverage is not provided by the employer and the employee's household income is 400% or less of the federal poverty level ($94,200 for a family of 4 in 2013).
- No Coverage Penalty. The Shared Responsibility Penalty for not offering Minimum Essential coverage is $2,000 per full-time employee (less 30 full-time employees).
- Insufficient Coverage Penalty. The Shared Responsibility Penalty for not offering Minimum Value Coverage that is Affordable Coverage is $3,000 per full-time employee receiving Premium Assistance.

Large Employer: Do You Have 50 Full-time or Full-time Equivalent Employees?

- Average of full-time employees during each of the 12 months in the **prior year**
- Employees who work at least **130 hours or more in a month** are full-time employees
- Add **full-time equivalencies**
  - The total number of hours worked by non full-time employees in a month (including seasonal employees) divided by 120
- Round average down (i.e., 49.7 is 49)
- Seasonal employees – Seasonal employees working less than four calendar months or 120 days (consecutive or nonconsecutive) may be disregarded if the employer exceeds 50 FTEs for 120 days or fewer during a calendar year. Migrant workers and holiday workers are typical seasonal employees, but may include other workers whose employment with an employer is “seasonal” or “periodic”.

Do You Provide Minimum Essential Coverage?

- **Minimum Essential Coverage**
  - Generally includes all health coverage except:
    - Limited scope dental or vision benefits
    - Coverage only for a specified disease or illness
    - Long-term care insurance
    - Other insurance coverage under which health care is not the primary benefit
  - Major medical plans generally constitute minimum essential coverage

No Coverage Penalty

- **No Coverage Penalty**
  - If the employer does not provide **minimum essential coverage** to at least 95% of its full-time employees and their **dependents** and
  - At least one full-time employee receives subsidized coverage on an exchange
  - Then the Coverage Penalty applies
    - $2,000 per full-time employee
    - Disregarding 30 full-time employees

Does Your Plan Provide Minimum Value?

- Minimum Value
  - A plan has minimum value if it pays 60% or more of the costs of medical benefits (determined actuarially)
  - Proposed regulations provide that minimum value may be calculated as follows
    - Minimum value calculator to be provided by HHS/IRS
    - Safe harbors established by HHS/IRS
    - Certification by actuary
  - Additional guidance is needed before minimum value can be reliably determined, but insurers/brokers/TPAs should be able to estimate minimum value

Is Your Plan Affordable?

- Affordable
  - Coverage is not affordable if the employee's premium for **employee-only coverage** exceeds 9.5% of the employee's household income
- IRS safe harbors
  - W-2 Safe Harbor - Coverage is affordable if it is 9.5% or less of the employee's W-2 income for the year (for the 2014 penalty, the 2014 W-2 issued in 2015 is used)
  - Rate of Pay Safe Harbor - Coverage is affordable if it is 9.5% or less of the employee's monthly rate of pay as of the beginning of the year
    - For hourly employees, the monthly rate of pay is the hourly rate times 130 hours
    - Not available if wages are reduced during the year
  - Federal Poverty Line Safe Harbor. Coverage is affordable if the cost is 9.5% or less of the federal poverty level for a single individual (2013 federal poverty level for a single individual is $11,490, making coverage affordable if it is $1,091.55 per year or less - $90.96 per month)
- Potential incentive to make coverage unaffordable to low wage earners so that their dependents qualify for subsidized coverage on the exchange

Insufficient Coverage Penalty

- **Insufficient Coverage Penalty**
  - If the employer does not provide coverage with **minimum value** and that is **affordable**
  - Then the Insufficient Coverage Penalty applies
    - $3,000 per full-time employee who receives subsidized coverage on an exchange
    - Capped at the No Coverage Penalty that would apply if the employer did not provide minimum essential coverage

Shared Responsibility Penalties

- Penalties are prorated and assessed monthly based on
  - **Actual full-time employees** (not FTEs) during the month
  - Actual receipt of subsidized exchange coverage **during the month**
- Safe harbor for variable wage and seasonal employees
  - If full-time/part-time status is unknown at time of hire
  - Employer can establish measurement periods of up to 12 months to determine status plus administrative period for enrollment
  - No penalty applies for employees who are not covered during measurement and administrative periods
  - Transition guidance applies allowing shorter measurement periods in 2013
- Fee is not deductible
- Employees generally include all “common law” employees
- All employees of the same “controlled group” are counted together, but the fee is assessed separately to each employer

What Employers Should Do Now

- Evaluate
  - Whether current coverage is provided to 95% of employees and dependents
  - Whether current coverage has minimum value and is affordable
- If not, consider plan design changes
  - Decrease hours of service requirement for eligibility (e.g., go from a 32 hours requirement to 30)
  - Reduce cost-sharing/add benefits/add HSA/HRA (minimum value) balanced against reduced premiums (affordability)
- If needed, develop procedures for determining whether variable-hour employees are full-time
- Review independent contractor and leased employee arrangements – shared responsibility significantly increases cost of mischaracterization
- Increase benefit plans-related due diligence in corporate transactions – consider indemnification covenants regarding shared responsibility fees
- Identify controlled groups and affiliated service groups.

Wellness Programs

- Maximum reward (or penalty) increased from 20% to 30% of cost of coverage, or up to 50% for tobacco cessation programs
- Other previously applicable requirements codified
  - Allow participants to qualify at least once per year
  - Program must be reasonably designed to prevent disease
  - If it is **unreasonably difficult** or **medically inadvisable** for an individual to meet the requirements of the program, the individual must be provided an **alternative** way to receive the benefits of the program
  - Must provide notice of the availability of alternatives
- In addition, employers with wellness programs should confirm that programs do not violate:
  - ADA – the EEOC has taken the position that wellness programs generally must be "voluntary" (i.e., no penalty or reward), but some courts disagree
  - GINA – cannot request genetic information unless program is voluntary

Transitional Reinsurance Program fee

- $25 billion will be collected from health plans and insurance companies to help stabilize the individual insurance market
- The fee applies from 2014 to 2016 and is estimated to be
  - $63 per average covered life in 2014
  - $42 per average covered life in 2015
  - $26.25 per average covered life in 2016
  - Actual fee will vary based on several factors determined by HHS
- Covered lives include participants, spouses and dependents
- Payment
  - Employees must report average covered lives to HHS by November 15 of the year (2014 report due by November 15, 2014)
  - HHS will provide notice of fee within 15 days
  - Fee is due within 30 days of notice

Transitional Reinsurance Program fee

- Methods for calculating average number of covered lives
  - Similar to PCORI methods (except generally only take into account 9 months of participation)
  - **Actual Count Method** – count covered lives on each day during the first 9 months of the year
  - **Snapshot Count Method** – count covered lives on at least one day per quarter during the first three quarters of the year
  - **Snapshot Factor Method** – count participants on at least one day per quarter during the first three quarters of the year and multiply participants with spouse/family coverage by 2.35
  - **Form 5500 Method** – add participant count on most recently filed Form 5500 on first day to participant count on last day (for employee-only plans, divide by 2)
- Retirees and COBRA beneficiaries are counted, except retirees with coverage that pays secondary to Medicare

Transitional Reinsurance Program fee

- Only comprehensive medical plans are subject to the fee
  - HRAs integrated with major medical, FSAs and HSAs are excluded
  - If insured, insurer pays the fee
  - If self-insured, plan pays the fee (it is a plan expense)
  - No double counting

On the Horizon

- Discrimination testing for insured plans (and possibly more detailed rules for self-insured plans)
  - Scheduled effective in 2011 but no enforcement until guidance is provided
- Automatic enrollment
  - For employers with 200 or more employees
  - Not applicable until guidance is issued (which will not happen until at least 2014)
- Quality of care reporting
  - Reporting requirements regarding whether a plan includes programs designed to improve health care outcomes (such as case management and wellness programs) and whether health care outcomes are actually improved
  - Not applicable until guidance is issued

Thank you!

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